Filing at a Glance

Company:	Kansas City Life Insurance Company
Product Name:	GA175 - GA176 (Health Filing)
State:	Arkansas
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	11/05/2012
SERFF Tr Num:	KCLF-128756442
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	GA175 - GA176 (HEALTH FILING)
Implementation Date Requested:	On Approval
Author(s):	Bobby Stow
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	11/05/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** Kansas City Life Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: GA175 - GA176 (Health Filing)
Project Name/Number: GA175 - GA176 (Health Filing)/GA175 - GA176 (Health Filing)

General Information

Project Name: GA175 - GA176 (Health Filing)
Project Number: GA175 - GA176 (Health Filing)
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 11/05/2012
State Status Changed: 11/05/2012
Created By: Bobby Stow
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Bobby Stow

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

With this filing, Kansas City Life Insurance Company is submitting for review and approval GA175-AR, Group Insurance Enrollment Form, and GA176-AR, Group Health Statement. The Medical Information Bureau, MIB, has mandated a change to the authorization found on the second page of each form. The required change has been made to previously approved GA173-AR, Group Insurance Enrollment Form, and GA128A, Group Health Statement, to comply with the MIB mandated change. GA173-AR was approved by the Arkansas Department of Insurance on December 11, 2008.

The authorizations contained on page 2 have been amended to include the MIB required change. The following sentence has been added to the authorization on page 2 of GA175-AR and GA176-AR: "I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB." No part of the applications have been altered or changed, and remain identical to the previously approved forms.

Company and Contact

Filing Contact Information

Bobby Stow, Compliance Analyst I
3520 Broadway St.
Kansas City, MO 64111

bstow@kclife.com
816-753-7299 [Phone] 8852 [Ext]
816-753-3018 [FAX]

Filing Company Information

Kansas City Life Insurance Company
P O Box 219139
Kansas City, MO 64121-9139
(800) 821-5529 ext. [Phone]

CoCode: 65129
Group Code: 588
Group Name:
FEIN Number: 44-0308260

State of Domicile: Missouri
Company Type: Life
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $100.00

State: *Arkansas* ***Filing Company:*** *Kansas City Life Insurance Company*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *GA175 - GA176 (Health Filing)*
Project Name/Number: *GA175 - GA176 (Health Filing)/GA175 - GA176 (Health Filing)*

Retaliatory? No

Fee Explanation: Application filing fee, $50.00 per form. Filing fee of $100.00 submitted.

Per Company: No

Company	Amount	Date Processed	Transaction #
Kansas City Life Insurance Company	$100.00	11/05/2012	64561878

SERFF Tracking #:	*KCLF-128756442*	***State Tracking #:***		***Company Tracking #:***	*GA175 - GA176 (HEALTH FILING)*

State:	*Arkansas*	***Filing Company:***	*Kansas City Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*GA175 - GA176 (Health Filing)*		
Project Name/Number:	*GA175 - GA176 (Health Filing)/GA175 - GA176 (Health Filing)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/05/2012	11/05/2012

SERFF Tracking #:	*KCLF-128756442*	***State Tracking #:***		***Company Tracking #:***	*GA175 - GA176 (HEALTH FILING)*

State:	*Arkansas*	***Filing Company:***	*Kansas City Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*GA175 - GA176 (Health Filing)*		
Project Name/Number:	*GA175 - GA176 (Health Filing)/GA175 - GA176 (Health Filing)*		

Disposition

Disposition Date: 11/05/2012
Implementation Date:
Status: Approved-Closed

HHS Status: HHS Approved
State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Statement of Variability - GA175-AR	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Group Insurance Enrollment Form	Approved-Closed	Yes
Form	Health Statement	Approved-Closed	Yes

SERFF Tracking #:	*KCLF-128756442*	***State Tracking #:***		***Company Tracking #:***	*GA175 - GA176 (HEALTH FILING)*

State:	*Arkansas*	***Filing Company:***	*Kansas City Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*GA175 - GA176 (Health Filing)*		
Project Name/Number:	*GA175 - GA176 (Health Filing)/GA175 - GA176 (Health Filing)*		

Form Schedule

Lead Form Number: GA175

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/05/2012	Group Insurance Enrollment Form	GA175-AR	AEF	Initial		42.700	GA175-AR.pdf
2	Approved-Closed 11/05/2012	Health Statement	GA176-AR	AEF	Initial			GA176-AR.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

K·C·L GROUP BENEFITS

Kansas City Life Insurance Company

GRP # _____

Group Insurance Enrollment Form

COMPLETED BY EMPLOYER

1. Employer		2. Location	
3. Full-time employment date	4. Occupation	5. Hours worked/week	6. Annual earnings
7. Coverage class	8. Rehire date	9. This enrollment is: (check all that apply) ☐Initial enrollment ☐Late entrant ☐New hire ☐Change ☐Other _____	

COMPLETED BY EMPLOYEE

10. Last Name, First Name, Middle Initial			
11. Home Address, City, State and Zip			
12. Social Security Number	13. ☐Male ☐Female	14. Date of Birth (M/D/Y)	15. ☐Single ☐Married

To apply for coverage(s), complete the following section and sign below. Indicate only those products available through your employer/plan sponsor.

16. Coverage(s) for Employee:	17. Coverage(s) for Dependents (Employee coverage required)
[☐Basic Life & AD&D ☐ Voluntary/Supplemental Life Amount: _____]	[☐Dependent Life]
[☐Dental If Applicable: ☐Low Plan ☐High Plan]	[☐Spouse Voluntary/Supplemental Life Amount:_____]
[☐Short-Term Disability ☐ Voluntary STD If Applicable: Amount: _____]	[☐Child/ren Voluntary/Supplemental Life Amount:_____]
[☐Long-Term Disability ☐ Voluntary LTD If Applicable: Amount: _____]	[Dental: ☐Spouse ☐Child/ren]
[☐Vision	[Vision: ☐Spouse ☐Child/ren]

[18. If COBRA continuee, please supply qualifying event and date:]

[19. Full Name of Primary Beneficiary and Relationship to you (applicable to life insurance only):]

[20. Full Name of Contingent Beneficiary and Relationship to you (applicable to life insurance only):]

For Dependent Coverage: List each dependent you wish to insure.

21. Name (show last name if different from employee)		Gender	Relationship	Date of Birth	[Other Dental Coverage]	
Spouse			N/A		Y	N
Child					Y	N
Child					Y	N
Child					Y	N
Child					Y	N

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage contained on the reverse side of this Enrollment Form.

22. Signature of Employee:_____ Date:_____

(To decline any coverages, complete "Declination of Coverage" on page 2.)

PLEASE DO NOT FILL IN SHADED AREA BELOW – HOME OFFICE USE ONLY

Group No. _____
Loc/Div _____
Cert. # _____

___Approved as requested
___Approved with changes
Employee _____
Spouse _____
Child/ren _____

By: _____
Date: _____

	Effective Date (M/D/Y)	Class	Coverage Amount
Basic Life& AD&D			
Basic Dep. Life			
Vol/Supp Life EE			
Vol/Supp Life SP			
Vol/Supp Life Child			
STD			
LTD			
Dental			
Vision			

*PROVISIONS OF COVERAGE

- I hereby apply to Kansas City Life Insurance Company for Group Insurance as presented to me and authorize my employer to make any necessary deduction from my wages to pay the premium when my insurance becomes effective.
- I represent I am not presently disabled and I am performing the material and substantial duties of my occupation for at least the number of hours as shown in column 5.
- Any person who knowingly presents a false for fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of crime and may be subject to fines and confinement in prison.
- I understand any material misstatement on this enrollment form may result in a denial of a claim and/or discontinuance of coverage.
- I have made a copy of this application for my records.

DECLINATION OF COVERAGE

To refuse coverage(s) for which you are required to pay a portion of the premium, please complete the following section:

Last Name, First Name, Middle Initial	Employer

Indicate Coverage(s) Declined Below:

Coverage(s) for Employee:

[___Basic Life & AD&D] [___Voluntary/Supplemental Life]
[___Dental] [___Voluntary STD]
[___Short-Term Disability] [___Voluntary LTD]
[___Long-Term Disability] [___Vision]

Coverage(s) for Dependents (Employee coverage required):

[Life: ___Spouse ___Child/ren]
[Dental: ___Spouse ___Child/ren]
[Vision: ___Spouse ___Child/ren]

Reason for refusing coverage: _____

I have been given an opportunity to participate in the group insurance plan offered by my employer. I am refusing the coverage indicated. I fully understand by this refusal, I and/or my dependents will not be entitled to any benefits under these coverages marked. If I and/or my Spouse or Child(ren) desire to participate at a later date, coverage(s) may be limited and proof of insurability may be required at my own expense.

Signature: _____ Date:_____

If requested to do so by Kansas City Life Insurance Company, please complete the following items.

Name of Employee:	Age	Gender	Height	Weight	Weight change in last year (gain/loss)
Name of Spouse of Employee (if applicable):	Age	Gender	Height	Weight	Weight change in last year (gain/loss)

During the past five years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition (including high blood pressure)*; cancer or tumor; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; arthritis or any other disease of the joints, including neck and back disorders; any mental, emotional or nervous disorder; any disorder of the brain, nervous, digestive or reproductive system; muscle or connective tissue disorder; alcohol or drug abuse; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

Employee: ☐Yes ☐No Spouse (life coverage only): ☐Yes ☐No

During the past five years, have you been declined coverage for any life or disability insurance?

Employee: ☐Yes ☐No Spouse (life coverage only): ☐Yes ☐No

For female, disability applicants only: Are you currently pregnant? ☐Yes ☐No

Please supply full details to "Yes" answers. List date(s) of onset, last occurrence, types of treatment including medication. *For high blood pressure, give date and last reading. If you require additional space, please attach separate sheet.

I(we) authorize the following to give information (defined below) to Kansas City Life Insurance Company or any person or group acting on the part of Kansas City Life Insurance Company: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts of: a medical nature regarding my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I(we) understand that this information will be used by Kansas City Life Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two and one-half years from the date signed. I (we) know that I(we) have a right to receive a copy of this Authorization upon request. I(we) agree that a photographic copy of this Authorization is as valid as the original.

I hereby represent that the above answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

Signature of Employee: _____ Date:_____

Signature of Spouse: _____ Date:_____

KANSAS CITY LIFE INSURANCE COMPANY

Group Number _____

Health Statement

Policyholder _____

Print full names of all to be insured.	Relationship to Primary Insured	Birthdate					Build			*Weight Change in past year	
		Month	Day	Year	Age	Sex	Ft.	In.	Lb.	Gain	Loss
1.											
2.											
3.											
4.											
5.											
6.											

Questions apply to all Proposed Insureds*

*__Give DETAILS__ to __Yes__ answers. Identify Proposed Insured(s), question, specify conditions, severity, dates, duration, after-effects, weight gain or loss, and names and addresses of all attending physicians and medical facilities.

	Yes	No
1. Do you take prescription medicine?	☐	☐
2. Are you currently pregnant? Due Date?_____	☐	☐
3. Have you ever used or received treatment or counseling for the use of marijuana, heroin, cocaine, amphetamines, barbiturates, hallucinogenic agents or opium or its derivatives?	☐	☐
4. Have any of the Proposed Insureds used any form of nicotine/tobacco in the last 12 months? (i.e., cigar, pipe, smokeless tobacco, cigarettes, etc.) If cigarettes, how many packs per day?_____	☐	☐
5. Have you sought advice, been treated or arrested for the use of alcohol?	☐	☐
During the **last 5 years** have you:		
6. been hospitalized or had medical advice, diagnostic tests recommended, or treatment by a physician or other medical practitioner?	☐	☐
During the **last 10 years** have you been diagnosed or treated for any disease or disorder of:		
7. brain and nervous system - mental illness, epilepsy, seizures, stroke, paralysis?	☐	☐
8. sight or hearing?	☐	☐
9. blood - anemia or leukemia?	☐	☐
10. tumor or cancer?	☐	☐
11. heart/blood vessels - murmur, chest pain or pressure, palpitations, heart attack?	☐	☐
12. blood pressure?	☐	☐
13. thyroid or glandular trouble?	☐	☐
14. lungs - asthma, emphysema, tuberculosis?	☐	☐
15. digestive system - ulcer, intestines or rectum, polyps, colitis?	☐	☐
16. liver - elevated enzymes, cirrhosis, hepatitis?	☐	☐
17. diabetes - sugar in urine?	☐	☐
18. kidney/bladder or prostate - albumin, blood or pus in urine?	☐	☐
19. bone, joint, muscles, back or spine - arthritis?	☐	☐
20. breasts, uterus, ovaries?	☐	☐
21. menstruation or pregnancy?	☐	☐
Have you ever been diagnosed or treated for:		
22. a sexually transmitted disease?	☐	☐
23. Acquired Immune Deficiency Syndrome (AIDS) or tested HIV positive?	☐	☐
24. In the **past 3 years,** have you applied for life or health insurance or reinstatement thereof, without receiving it exactly as requested?	☐	☐

Names, addresses and phone numbers of personal or family physicians. (If none, list last physician, clinic or hospital consulted.)

Date and Reason;_____ Clinic or VA last consulted: _____

_____ Claim Number: _____

Agreement and Signatures

It is understood and agreed as follows:

1. The statements and answers recorded in all parts of this application are true and complete.
2. No information regarding any Proposed Insured(s) will be considered known by the Company unless explicitly set out in writing on this application.
3. This application, and the answers to any required medical exam, will become a part of any insurance issued on it.
4. No agent has the authority to waive any of the Company's rights or rules, or to make or change any contract.
5. I (We) have received the Notice of Information Practices which explains my (our) rights under the Fair Credit Reporting Act.

AUTHORIZATION: I (We) authorize the following to give information (defined below) to Kansas City Life or any person or group acting on the part of Kansas City Life: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts of: a medical nature in regard to my (our) physical or mental condition; employment; other insurance coverage; or any other non-medical facts.

I (We) understand that this information will be used by Kansas City Life to determine eligibility for insurance. I (We) agree this Authorization is valid for two and one-half years from the date signed.

I (We) know that I (we) have a right to receive a copy of this Authorization upon request.

I (We) agree that a photographic copy of this Authorization is as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ (City, State) this _____ (Day) day of _____ (Month), _____ (Year)

_____ **Employee's Signature**

_____ **Spouse's Signature** (if coverage applied for)

EMPLOYER SECTION:

Reason for Submitting Health Statement:

☐ Late Applicant ☐ Adding Coverage ☐ Other _____

☐ Late Dependent ☐ Increasing Coverage _____

Coverage Type and Amount Applying For:

☐ Life $_____ ☐ WDI $ _____

☐ Supplemental Life $_____ ☐ LTD $ _____

☐ Dependent Life: Spouse _____ Child _____

_____ _____ _____

Information Provided By Phone # Date

HOME OFFICE USE ONLY:

Basic Max._____ EOI _____

Supp. Max _____ EOI _____

Combined Max. _____ EOI _____

WDI Max. _____

LTD Max. _____

Notes: _____

_____

_____

Amount to be Approved Basic _____

Supp. _____

Total _____

Underwriting Action:

Approved ☐

Declined ☐

Withdrawn ☐

UND. | Decision Date

Notes:

KANSAS CITY LIFE
INSURANCE COMPANY

To obtain further information contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-9371

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and issuing your contract. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living (except as may be related directly or indirectly to your sexual orientation) as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address above. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We are committed to protecting the privacy of our customer's nonpublic personal information. We will only disclose our customer's nonpublic personal information: among the affiliated companies of the Kansas City Life Group; to provide services to our customers and administer our business; to market products; and as otherwise permitted by law. We may disclose our customer's nonpublic personal information to our agents and representatives to provide services to our customers and for marketing purposes. When we contract with other entities to provide support or marketing services, we will require them to adhere to our privacy standards.

Sometimes we acquire medical information about our customers, for instance, to underwrite an insurance contract or to process an insurance claim. We will keep our customer's medical information confidential. We will not share our customer's medical information even among the affiliated companies of the Kansas City Life Group without the customer's consent. We will only use or disclose our customer's medical information to underwrite insurance, process claims, administer our business, to comply with laws and regulations or as otherwise authorized by our customers.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our New Business Department, Kansas City Life Insurance Company, PO Box 219371, Kansas City, MO 64121-9371.

MIB, Inc. Notice

While the information you provide to us regarding you insurability is treated as confidential, Kansas City Life or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file.

Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is PO Box 105, Essex Station, Boston, MA 02112. Telephone (617) 426-3660.

We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

SERFF Tracking #:	*KCLF-128756442*	***State Tracking #:***	***Company Tracking #:*** *GA175 - GA176 (HEALTH FILING)*

State:	*Arkansas*	***Filing Company:***	*Kansas City Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*GA175 - GA176 (Health Filing)*		
Project Name/Number:	*GA175 - GA176 (Health Filing)/GA175 - GA176 (Health Filing)*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	11/05/2012
Comments:			
Attachment(s):			
Filing Certification - Arkansas.pdf Readability Certification - Arkansas.pdf			

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved-Closed	11/05/2012
Bypass Reason:	N/A. This is an application filing.		

		Item Status:	**Status Date:**
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	11/05/2012
Bypass Reason:	N/A. This is an application filing.		

		Item Status:	**Status Date:**
Bypassed - Item:	Outline of Coverage	Approved-Closed	11/05/2012
Bypass Reason:	N/A. Not applicable to this filing.		

		Item Status:	**Status Date:**
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/05/2012
Bypass Reason:	N/A. Not applicable to this filing.		

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability - GA175-AR	Approved-Closed	11/05/2012
Comments:	Attached is a Statement of Variability for GA175-AR.		
Attachment(s):			
Statement of Variability for GA175.pdf			

		Item Status:	**Status Date:**

SERFF Tracking #:	*KCLF-128756442*	***State Tracking #:***	***Company Tracking #:*** *GA175 - GA176 (HEALTH FILING)*

State:	*Arkansas*	***Filing Company:***	*Kansas City Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*GA175 - GA176 (Health Filing)*		
Project Name/Number:	*GA175 - GA176 (Health Filing)/GA175 - GA176 (Health Filing)*		

Satisfied - Item:	Cover Letter	Approved-Closed	11/05/2012
Comments:	Attached is a letter describing the filing.		
Attachment(s):			
Cover Letter - Arkansas.pdf			

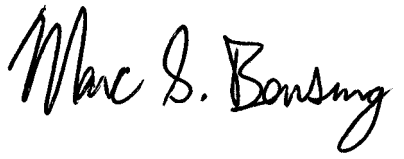
STATE OF ARKANSAS
COMPLIANCE CERTIFICATION

COMPANY NAME: Kansas City Life Insurance Company

FORM TITLE(S): Group Insurance Enrollment Form, Health Statement

FORM NUMBER(S): GA175-AR, GA176-AR

I hereby certify that to the best of my knowledge and belief, the above form and submissions is in compliance with Regulation 19, Regulation 49, and all other laws, rules and regulations of the State of Arkansas.

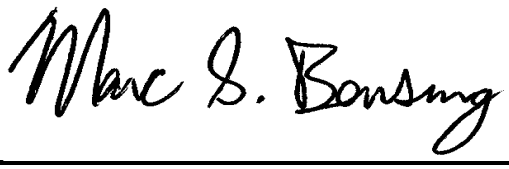


Marc S. Bensing
Assistant Vice President
Kansas City Life Insurance Company

October 16, 2012

READABILITY CERTIFICATION

Form	Score
GA175-AR	42.7



Name: Marc Bensing
Title: Assistant Vice President
Company: Kansas City Life Insurance Company
Date: October 16, 2012

Variable Listing for GA175 - Group Insurance Enrollment Form

Box 16. Coverages for Employee

(Any of these coverages may be removed if policyholder did not purchase.)

Box 17. Coverages for Dependents

(Any of these coverages may be removed if policyholder did not purchase.)

Box 18, 19, 20 - Cobra and Beneficiary info

(Any of these fields may be removed if policyholder did not purchase dental or life coverage.)

Box 21. Other Dental Coverage

(May be removed if Dental not purchased.)

Declination of Coverage

(Any of these coverages may be removed if policyholder did not purchase.)

KANSAS CITY LIFE
INSURANCE COMPANY
Broadway at Armour / Box 219139 / Kansas City, Missouri 64121-9139
Telephone: (816) 753-7000

October 23, 2012

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, Arkansas 72201-1904

RE: Kansas City Life Insurance Company
NAIC: 65129-588
FEIN: 44-0308260
Application Filing: MIB mandated change to Group Insurance Enrollment Form and Group Health Statement

Dear Sir or Madam:

With this filing, Kansas City Life Insurance Company is submitting for review and approval GA175-AR, Group Insurance Enrollment Form, and GA176-AR, Group Health Statement. The Medical Information Bureau, MIB, has mandated a change to the authorization found on the second page of each form. The required change has been made to previously approved GA173-AR, Group Insurance Enrollment Form, and GA128A, Group Health Statement, to comply with the MIB mandated change. GA173-AR was approved by the Arkansas Department of Insurance on December 11, 2008.

The authorizations contained on page 2 have been amended to include the MIB required change. The following sentence has been added to the authorization on page 2 of GA175-AR and GA176-AR: "I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB." No part of the applications have been altered or changed, and remain identical to the previously approved forms.

Please direct all inquiries regarding this filing to me at the address, phone number, or email address contained in the file.

Sincerely,

Bobby Stow
Compliance Analyst
Kansas City Life Insurance Company
Phone: 800.821.6164
Ex: 8852
Email: bstow@kclife.com